		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0007153

Facility Name: BURNSIDE NURSING HOME

Address: 410-412 N. SECOND ST. (Number) MARSHALL (City) 62441 (Zip Code)

County: CLARK

Telephone Number: (217) 826-2358 **Fax #** (217) 826-2367

IDPA ID Number: 37-0841315001

Date of Initial License for Current Owners: SEPT. 1963

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL		
	X	Charitable Corp.		Individual		State	
		Trust		Partnership		County	
IRS Exemption Code				Corporation		Other	
				"Sub-S" Corp.			
				Limited Liability Co.			
				Trust			
				Other			

In the event there are further questions about this report, please contact:
Name: PATRICK E. BELL, CPA **Telephone Number:** (217) 465-6494

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/99 to 06/30/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Jackie Williams
(Title) Administrator

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) PATRICK E. BELL, CPA
(Firm Name & Address) LARSSON, WOODYARD & HENSON, LLP
702 E. COURT STREET PARIS, IL 61944
(Telephone) (217) 465-6494 Fax # (217) 465-6499

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BURNSIDE NURSING HOME # 0007153 Report Period Beginning: 07/01/99 Ending: 06/30/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 119

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	119	Skilled (SNF)	119	43,554	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	119	TOTALS	119	43,554	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	15,587	19,942		35,529	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,587	19,942		35,529	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.57%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
MEALS ON WHEELS

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started September 1963

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified and days of care provided

Medicare Intermediary

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 06/30/00 Fiscal Year: 06/30/00

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BURNSIDE NURSING HOME # 0007153 Report Period Beginning: 07/01/99 Ending: 06/30/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	248,729	25,154	7,350	281,233		281,233		281,233			1
2	Food Purchase		168,814		168,814		168,814	(27,183)	141,631			2
3	Housekeeping	107,529	38,618		146,147		146,147		146,147			3
4	Laundry	83,790	28,002		111,792		111,792		111,792			4
5	Heat and Other Utilities			125,800	125,800		125,800		125,800			5
6	Maintenance	76,751	7,453	46,704	130,908		130,908		130,908			6
7	Other (specify):*											7
8	**TOTAL General Services**	516,799	268,041	179,854	964,694		964,694	(27,183)	937,511			8
	B. Health Care and Programs											
9	Medical Director			3,300	3,300		3,300		3,300			9
10	Nursing and Medical Records	1,347,783	134,023	9,764	1,491,570	2,391	1,493,961		1,493,961			10
10a	Therapy			4,950	4,950		4,950		4,950			10a
11	Activities	60,804	2,392	2,094	65,290		65,290		65,290			11
12	Social Services	28,427		2,500	30,927		30,927		30,927			12
13	Nurse Aide Training			5,823	5,823		5,823		5,823			13
14	Program Transportation			767	767		767		767			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,437,014	136,415	29,198	1,602,627	2,391	1,605,018		1,605,018			16
	C. General Administration											
17	Administrative	53,908			53,908		53,908		53,908			17
18	Directors Fees											18
19	Professional Services			23,030	23,030		23,030		23,030			19
20	Dues, Fees, Subscriptions & Promotions			12,393	12,393		12,393	(609)	11,784			20
21	Clerical & General Office Expenses	48,772	9,042	816	58,630		58,630		58,630			21
22	Employee Benefits & Payroll Taxes			320,610	320,610	5,068	325,678	(2,363)	323,315			22
23	Inservice Training & Education											23
24	Travel and Seminar			11,729	11,729	(7,459)	4,270		4,270			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			17,231	17,231		17,231		17,231			26
27	Other (specify):*											27
28	**TOTAL General Administration**	102,680	9,042	385,809	497,531	(2,391)	495,140	(2,972)	492,168			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,056,493	413,498	594,861	3,064,852		3,064,852	(30,155)	3,034,697			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number BURNSIDE NURSING HOME #0007153 Report Period Beginning: 07/01/99 Ending: 06/30/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			115,831	115,831		115,831	(18,888)	96,943			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			36,128	36,128		36,128	(25,389)	10,739			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			151,959	151,959		151,959	(44,277)	107,682			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			65,331	65,331		65,331		65,331			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			65,331	65,331		65,331		65,331			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,056,493	413,498	812,151	3,282,142		3,282,142	(74,432)	3,207,710			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BURNSIDE NURSING HOME # 0007153 Report Period Beginning: 07/01/99 Ending: 06/30/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(27,183)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(25,389)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(355)	20		28
29	Other-Attach Schedule	(21,505)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	$ (74,432)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	$		36
37	TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))	$ (74,432)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology			N/A		42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 5A

BURNSIDE NURSING HOME

ID# 0007153

Report Period Beginning: 07/01/99

Ending: 06/30/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	NON-CARE DEPRECIATION	$ (18,888)	30	1
2	EMPLOYEE RECOGNITION	(2,363)	22	2
3	PATIENT SUBSCRIPTIONS	(254)	20	3
4				4
5				5
6				6
7				7
8				8
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89				89
90	Total	(21,505)		90

STATE OF ILLINOIS — Summary A

Facility Name & ID Number BURNSIDE NURSING HOME # 0007153 **Report Period Beginning:** 07/01/99 **Ending:** 06/30/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(27,183)	0	0	0	0	0	0	0	0	0	0	(27,183)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(27,183)	0	0	0	0	0	0	0	0	0	0	(27,183)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(609)	0	0	0	0	0	0	0	0	0	0	(609)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	(2,363)	0	0	0	0	0	0	0	0	0	0	(2,363)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(2,972)	0	0	0	0	0	0	0	0	0	0	(2,972)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(30,155)	0	0	0	0	0	0	0	0	0	0	(30,155)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BURNSIDE NURSING HOME # 0007153 **Report Period Beginning:** 07/01/99 **Ending:** 06/30/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(18,888)	0	0	0	0	0	0	0	0	0	0	(18,888)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(25,389)	0	0	0	0	0	0	0	0	0	0	(25,389)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(44,277)	0	0	0	0	0	0	0	0	0	0	(44,277)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(74,432)	0	0	0	0	0	0	0	0	0	0	(74,432)	45

Facility Name & ID Number BURNSIDE NURSING HOME # 0007153 Report Period Beginning: 07/01/99 Ending: 06/30/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		NON-APPLICABLE				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$	NON-APPLICABLE		$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BURNSIDE NURSING HOME # 0007153 Report Period Beginning: 07/01/99 Ending: 06/30/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	NON-APPLICABLE								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number BURNSIDE NURSING HOME # 0007153 Report Period Beginning: 07/01/99 Ending: 06/30/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					N/A	$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BURNSIDE NURSING HOME # 0007153 Report Period Beginning: 07/01/99 Ending: 06/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	UNION PLANTERS		X	MORTGAGE	$4,950.00	6/15/95	$ 600,000	$ 479,805	06/15/10	0.0715	$ 35,550	1
2	MTS DIGITAL		X	LEASE TO PURCHASE	$140.00	01/26/98	4,470	2,062	11/21/01	0.2030	548	2
3	DULANEY NATIONAL BANK		X	LOC	N/A	01/06/99	200,000		01/06/00	0.0800	30	3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$5,090.00		$ 804,470	$ 481,867			$ 36,128	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 804,470	$ 481,867			$ 36,128	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BURNSIDE NURSING HOME # 0007153 Report Period Beginning: 07/01/99 Ending: 06/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$		3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	N/A	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	#VALUE!	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1995	8
	1996	9
	1997	10
	1998	11
	1999	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number BURNSIDE NURSING HOME # 0007153 Report Period Beginning: 07/01/99 Ending: 06/30/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 46,819 B. General Construction Type: Exterior BDFDST/LIMEST Frame WOOD Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

Robert Flowers Village- Independent Living Facility- 8 units
Burnhaven Apartments- Independent Living Facility- 8 units
Cork Medical Center- provides outpatient medical care- leased to unrelated party

All of the above facilities have their own accounting records and share no common costs with Burnsides Nursing Home.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1		226,425	1963	$ 22,963	1
2		8,400	1982	12,376	2
3	TOTALS	234,825		$ 35,339	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BURNSIDE NURSING HOME # 0007153 Report Period Beginning: 07/01/99 Ending: 06/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	111		1963	1963	$ 561,968	$	15,30	$	$	$ 539,010	4
5			1969	1969	90,727		30			90,727	5
6			1980	1980	28,475	1,424	20	1,424		27,755	6
7			1981	1981	59,429	2,048	20,30	2,048		37,895	7
8			1982	1982	63,314	1,398	15,30	1,398		52,511	8
	Improvement Type**										
9	ELEVATOR			1965	8,581		20			8,581	9
10	SAFETY DOOR AND IMPROVEMENTS			1972	9,375		10			9,375	10
11	IMPROVEMENTS			1974	4,562		10			4,562	11
12	SPRINKLER SYSTEM			1975	39,041		20			38,065	12
13	IMPROVEMENTS			1977	2,892		10			2,892	13
14	IMPROVEMENTS			1978	636		10			636	14
15	IMPROVEMENTS, DRAPES			1979	12,447		10			12,447	15
16	AWNING, DINING ROOM WINDOWS			1981	73,295	2,652	10,30	2,652		52,180	16
17	DRAPES, GUTTERING, DRAINAGE, DINING ROOM ROOF			1982	33,034		10,15			33,034	17
18	DRAPES			1983	5,526		15			5,526	18
19	DRAPES, LIGHTING, & KITCHEN CABINET DOORS			1984	7,163	89	10,15	89		7,163	19
20	FIRE SYSTEM KITCHEN, DRAPES, STEEL WALL KITCHEN			1985	25,383	754	5,25	754		21,429	20
21	LIGHTS, CALL SYSTEM, REMODELING, DRAPES, ROOF			1986	88,718	4,000	5,25	4,000		74,570	21
22	SPRINKLERS, CARPET, DRAPES			1987	17,180	488	5,25	488		14,791	22
23	BUILDING IMPROVEMENTS, WATER PUMP, SEWER			1988	10,413	449	8,20	449		7,177	23
24	SMOKE DETECTOR, REMODELING, AIR CONDITIONER			1989	50,606	2,548	5,20	2,548		30,968	24
25	DOOR ALARM, FIRE ALARMS, REMODELING			1990	15,363	1,083	10,20	1,083		10,759	25
26	REMODELING			1991	4,055	373	10,20	373		3,344	26
27	CARPET			1992	228	10	10	10		173	27
28	OFFICE REMODELING DOORS			1993	8,177	786	10,20	786		5,633	28
29	WATER SYSTEM, WINDOWS			1994	5,079	352	10,20	352		2,119	29
30	NEW WING ADDITION			1995	88,453	5,224	10,20	5,224		25,311	30
31	WALLPAPER, BLINDS, PHONE SYSTEM			1996	4,335	217	20	217		907	31
32	CEILING WORK, INSULATION			1997	24,991	1,250	20	1,250		3,490	32
33	BACKFLOW SYSTEM/SPRINKLER SYSTEM			1998	2,990	150	20	150		311	33
34	ROOFING			1999	29,927	1,496	20	1,496		2,285	34
35	REMODELING- HANDRAILS			1999	3,994	200	20	200		267	35
36	TOTAL (lines 4 thru 35)				$ 1,380,357	$ 26,991		$ 26,991	$	$ 1,125,893	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BURNSIDE NURSING HOME # 0007153 Report Period Beginning: 07/01/99 Ending: 06/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1984	1984	$ 17,127	$ 605	15	$ 605	$	$ 9,531	4
5			1985	1985	2,869	164	15	164		2,621	5
6	8		1995	1995	1,100,822	28,196	40	28,196		135,088	6
7			1997	1997	737,255	18,888	10,40	18,888		50,708	7
8			1997	1997	(737,255)	(18,888)		(18,888)		(50,708)	8
	Improvement Type**										
9	NEW GREASE TRAP KITCHEN			1999	965	48	20	48		56	9
10	TV WALL MOUNTS			1999	232	23	10	23		44	10
11	VANITY & TOP KITCHEN			1999	174	9	20	9		17	11
12	PAINT & BORDER			1999	2,048	102	20	102		179	12
13	LEVER ENTRY KNOBS			1999	690	34	20	34		60	13
14	CUBICLE CURTAINS			1999	740	74	10	74		111	14
15	FAUCET WALL MOUNT			1999	747	37	20	37		56	15
16	WINDOW NON SMOKING BREAKROOM			1999	146	7	20	7		8	16
17	ALMOND PANELING			1999	1,457	70	20	70		70	17
18	REROUTE D WING HEAT AND RECP CIRCUIT			1999	400	19	20	19		19	18
19	PARKING LOT			1973	19,280		10			19,280	19
20	LANDSCAPING			1974	2,891		10			2,891	20
21	PARKING LOT IMPROVEMENTS			1975	3,989		10			3,989	21
22	BLACKTOP SEALING, CULVERT INSTALLATION			1980	13,853		10			13,853	22
23	BLACKTOP AT SHED, SEWER			1981	5,170		15			5,150	23
24	LANDSCAPING, GRADING, PARKING LOT IMPROVEMENTS			1982	15,497		5,15			15,497	24
25	ASPHALT SEALING			1983	3,511		5			3,511	25
26	LANDSCAPING, ROAD IMPROVEMENTS			1984	4,350		5,10			4,350	26
27	LANDSCAPING AT CHAPEL			1988	675		10			675	27
28	LANDSCAPING			1989	220		10			220	28
29	ROAD RESURFACING			1990	9,188	593	5,15	593		6,320	29
30	ROCK			1992	330	33	10	33		270	30
31	ASPHALT SEALING			1993	20,570		5			20,570	31
32	LANDSCAPING, FIRE HYDRANT			1995	4,807	294	10,20	294		1,515	32
33	PARKING LOT PAVING			1999	11,850	1,185	10	1,185		2,370	33
34	LANDSCAPING			2000	500	25	19	25		25	34
35	CHAPEL			1985	229,191	7,284	10,30	7,284		120,544	35
36	TOTAL (lines 4 thru 35)				$ 1,474,289	$ 38,802		$ 38,802	$	$ 368,890	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BURNSIDE NURSING HOME # 0007153 Report Period Beginning: 07/01/99 Ending: 06/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	DRAPES AND CARPET			1986	4,252	71	5.15	71		4,188	9
10	RECLASIFICATIONS FROM IDPA DESK REVIEW				18,478	1,432		1,432		10,100	10
11											11
12	ASSETS DISPOSED OF (INCL. ABOVE):										12
13											13
14	CARPET			1989	(216)					(216)	14
15	PANELING FOR E-WING DAY ROOM			1989	(1,158)					(606)	15
16	CUBICLE TRACK & CURTAINS			1989	(350)					(346)	16
17	CARPET FRONT ENTRY WAY			1992	(228)					(173)	17
18	DRAPES AND SHADES			1979	(604)					(604)	18
19	FLAT ROOF- DINING ROOM			1982	(7,638)					(7,638)	19
20	EMPLOYEE DINING ROOM DRAPES			1985	(300)					(300)	20
21	DINING ROOM DRAPES			1986	(6,213)					(5,466)	21
22	ROOFING			1986	(14,531)					(7,632)	22
23	CURTAINS			1987	(7,639)					(7,639)	23
24	CUBICLE DIVIDER CURTAIN			1988	(1,063)					(1,063)	24
25	CARPET			1987	(269)					(269)	25
26	S ROOM DARKENING BLIND			1989	(93)					(93)	26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ (17,572)	$ 1,503		$ 1,503	$	$ (17,757)	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BURNSIDE NURSING HOME # 0007153 Report Period Beginning: 07/01/99 Ending: 06/30/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 327,481	$ 29,366	$ 29,366	$		$ 172,223	37
38	Current Year Purchases	28,253	1,713	1,713			1,413	38
39	Fully Depreciated Assets	153,818					153,818	39
40	IDPA RECL DESK REV	(18,478)	(1,432)	(1,432)			(10,100)	40
41	TOTALS	$ 491,074	$ 29,647	$ 29,647	$		$ 317,354	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	LOCAL TRNSPTN	1981 GMC VAN	1981	$ 13,873	$	$	$	5	$ 13,873	42
43	LOCAL TRANSPTN	1987 DODGE PICKUP	1987	8,212				5	8,212	43
44										44
45										45
46	TOTALS			$ 22,085	$	$	$		$ 22,085	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$	3,385,572	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$	96,943	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$	96,943	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$		50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$	1,816,465	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	BURNHAVEN APTS.	$ 737,255	$ 18,888	$ 50,708	52
53					53
54					54
55					55
56					56
57	TOTALS	$ 737,255	$ 18,888	$ 50,708	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59	N/A		59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number BURNSIDE NURSING HOME # 0007153 Report Period Beginning: 07/01/99 Ending: 06/30/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$ N/A			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ Description: N/A
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$ N/A	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BURNSIDE NURSING HOME # 0007153 Report Period Beginning: 07/01/99 Ending: 06/30/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM	
IN OTHER FACILITY	X
COMMUNITY COLLEGE	
HOURS PER AIDE	80

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	
IN OTHER FACILITY	X
HOURS PER AIDE	40

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$ 5,823	$	$ 5,823
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$ 5,823	$	$ 5,823
10	SUM OF line 9, col. 1 and 2 (e)	$ 5,823			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	14
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	14

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs				N/A		#VALUE!	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$ #VALUE!	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BURNSIDE NURSING HOME # 0007153 Report Period Beginning: 07/01/99 Ending: 06/30/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 63,273	$	1
2	Cash-Patient Deposits	2,277		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	132,915		3
4	Supply Inventory (priced at)	31,432		4
5	Short-Term Investments	367,578		5
6	Prepaid Insurance	42,605		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): INTEREST REC.	282		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 640,362	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	35,339		13
14	Buildings, at Historical Cost	2,661,985		14
15	Leasehold Improvements, at Historical Cost	893,865		15
16	Equipment, at Historical Cost	531,637		16
17	Accumulated Depreciation (book methods)	(1,867,173)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,255,653	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,896,015	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 63,385	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	151,026		30
31	Accrued Taxes Payable (excluding real estate taxes)	23,616		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	1,133		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Trust Account	2,277		36
37	Short Term Portion of LTD	27,376		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 268,813	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	454,491		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 454,491	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 723,304	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,172,711	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,896,015	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number BURNSIDE NURSING HOME # 0007153 Report Period Beginning: 07/01/99 Ending: 06/30/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,152,222	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,152,222	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	4,999	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 4,999	17
	B. Transfers (Itemize):		
18	INTERDIVISIONAL TRANSFER	6,000	18
19	PRIOR PERIOD ADJUSTMENT	9,490	19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 15,490	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,172,711	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BURNSIDE NURSING HOME # 0007153 Report Period Beginning: 07/01/99 Ending: 06/30/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,237,235	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,237,235	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	2,012	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,012	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	27,183	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 27,183	23
	D. Non-Operating Revenue		
24	Contributions	2,783	24
25	Interest and Other Investment Income***	25,389	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 28,172	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending Income 894, Activity Sold 71, Misc. Inc. 800 &		28
28a	Sale of Fixed Asets (9,226)	(7,461)	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (7,461)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,287,141	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	964,694	31
32	Health Care	1,602,627	32
33	General Administration	497,531	33
	B. Capital Expense		
34	Ownership	151,959	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	65,331	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,282,142	40
41	**Income before Income Taxes (line 30 minus line 40)****	4,999	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 4,999	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

******Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number BURNSIDE NURSING HOME # 0007153 Report Period Beginning: 07/01/99 Ending: 06/30/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,160	2,208	$ 41,643	$ 18.86	1
2	Assistant Director of Nursing	2,160	2,296	40,580	17.67	2
3	Registered Nurses	15,078	16,318	252,962	15.50	3
4	Licensed Practical Nurses	21,966	24,185	277,662	11.48	4
5	Nurse Aides & Orderlies	85,148	92,219	676,707	7.34	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,025	2,040	19,453	9.54	9
10	Activity Assistants	5,927	6,177	41,351	6.69	10
11	Social Service Workers	2,808	2,820	28,427	10.08	11
12	Dietician					12
13	Food Service Supervisor	2,160	2,168	20,086	9.26	13
14	Head Cook					14
15	Cook Helpers/Assistants	31,458	33,878	228,643	6.75	15
16	Dishwashers					16
17	Maintenance Workers	7,470	8,017	76,751	9.57	17
18	Housekeepers	15,861	17,093	107,529	6.29	18
19	Laundry	11,270	11,915	83,790	7.03	19
20	Administrator	2,160	2,224	53,908	24.24	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,160	2,184	22,249	10.19	23
24	Clerical	3,748	4,035	26,523	6.57	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) REHAB	5,420	6,404	58,229	9.09	33
34	TOTAL (lines 1 - 33)	218,979	236,181	$ 2,056,493 *	$ 8.71	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	170	$ 7,350	1-3	35
36	Medical Director	MO FEE	3,300	9-3	36
37	Medical Records Consultant	MO FEE	1,520	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	MO FEE	1,200		39
40	Physical Therapy Consultant	MO FEE	4,950	10A-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	31	2,094	11-3	44
45	Social Service Consultant	31	2,500	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	232	$ 22,914		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	N/A			51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jackie Williams	Administrator	0.00%	$ 53,908
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 53,908

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Other	ADM CONSULT.	$ 798
Randolph Rich	LEGAL	50
Holleb & Coff	LEGAL	5,875
Larsson Woodyard & Henson	ACCOUNTING	12,625
Larsson Woodyard & Henson	COMPUTER SERV.	3,682
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 23,030

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 19,617
Unemployment Compensation Insurance	7,053
FICA Taxes	161,776
Employee Health Insurance	65,319
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Flex Contributions	59,132
Flex Administration	2,960
Educational Assistance	7,458
TOTAL (agree to Schedule V, line 22, col.8)	$ 323,315

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	754
Health Care Worker Background Check	540
(Indicate # of checks performed 45)	
Other Advertising	2,738
Fees	445
Dues	5,494
Subscriptions	2,422
Patient Subscriptions	(254)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	(355)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,784

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,652
Educational Material	618
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,270

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BURNSIDE NURSING HOME # 0007153 Report Period Beginning: 07/01/99 Ending: 06/30/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9					N/A								
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number BURNSIDE NURSING HOME # 0007153 Report Period Beginning: 07/01/99 Ending: 06/30/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IHCA $4,595**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **NO** If YES, have these costs
been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YRS.**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **49,732** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **65,331**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **NO** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classifiec
in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **NO** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **NONE** Has any meal income been offset against
related costs? **YES** Indicate the amount. $ **27,183**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **NO** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such
transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **LARSSON, WOODYARD & HENSON, LLP** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? **YES** If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.